Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5884AGC	A. BUILDING _____ B. WING _____	R-C 03/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NAZARENE SENIOR CARE HOME	5362 TOPAZ ST LAS VEGAS, NV 89120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a required grading re-survey and follow-up survey conducted in your facility on 3/7/11 after a high level deficiency was identified in a previous survey. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for four Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was three. Three resident files were reviewed and one employee files were reviewed. The facility received a grade of A. The following deficiencies were identified:	Y 000		
Y 104 SS=C	449.200(1)(e) Personnel File - References NAC 449.200 1. Except as otherwise provided in subsection 2, a separate personnel file must be kept for each member of the staff of a facility and must include: (e) Evidence that the references supplied by the employee were checked by the residential facility.	Y 104		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 104	Continued From page 1 This Regulation is not met as evidenced by: Based on record review on 3/7/11, the facility failed to investigate the references on 1 of 1 employees (Employee #1). This was a repeat deficiency from the 12/13/10 State Licensure survey. Severity: 1 Scope: 3	Y 104		